Prescription Drugs

As long as you are enrolled in a Starbucks medical plan administered by Premera, the prescription drug plan will cover you and your enrolled dependents when you need a prescription filled.

How the Plan Works

Coverage for prescription drugs is an important part of your medical coverage. If you are enrolled in Routine Care PPO or Your Care PPO, coverage for prescription drugs is provided through Medco Health as part of your Premera medical plan.

Pharmacy network

If you are enrolled in Your Care PPO Plus, you can visit any pharmacy to fill your prescription. However, if you visit a pharmacy that participates in Premera's Medco network, you will pay less for your prescriptions. If you are covered under Your Care PPO Standard or Routine Care PPO Plus or Standard, you must visit a participating Medco pharmacy to receive coverage for any prescription filled.

Premera contracts with over 60,000 retail pharmacies, including a number of large nationwide pharmacy chains, as well as local independent pharmacies, so you have lots of options when it comes to filling a prescription.

And, to save even more money, you can use the Medco By Mail service if your prescription is for a maintenance medication written for up to a 90-day supply. Maintenance medications are those prescription drugs that are taken on a routine, ongoing basis. Examples of maintenance medications include oral contraceptives and heart or diabetes medications.

COVERAGE FOR PREMERA MEDCO PHARMACIES ONLY	COVERAGE FOR PREMERA MEDCO PHARMACIES AND OTHER OUT-OF-NETWORK PHARMACIES
• Your Care PPO Standard • Routine Care PPO Plus and Standard	• Your Care PPO Plus

Participating pharmacies

When you visit a participating pharmacy, there are a few advantages: you will pay less and you will not need to submit a claim form. Simply present your Premera medical ID card at the time you are ordering your prescription and make the necessary payment. Pharmacies participating in the Premera network include a variety of independent pharmacies, as well as local and national chains.

To view a complete list of participating pharmacies near you, link to Premera's pharmacy directory from www.mysbuxben.com or call Premera at (877) 728-9020.

Nonparticipating pharmacies

When you visit a pharmacy that does not belong to Premera's pharmacy network, you will pay more to have your prescriptions filled (and you're only covered for nonparticipating pharmacies with the Your Care PPO Plus plan). You will need to pay the full cost of your prescriptions when they are filled and submit a claim to Premera to be reimbursed. You can obtain a claim form online at the Forms/Resources page at www.mysbuxben.com or by calling Premera Partner Services at (877) 728-9020. Return your completed claim form and attached pharmacy receipt to Premera at the address shown on the claim form. See "How to file a claim" on page 89 for more information.

Prescription Drug Coverage Overview

PLAN	PARTICIPATING (IN-NETWORK) PHARMACY For up to a 30-day supply you pay	NON-PARTICIPATING (OUT-OF-NETWORK) PHARMACY For up to a 30-day supply you pay	MEDCO BY MAIL For up to a 90-day supply you pay
Your Care PPO Plus (When you take HQ)	• $10 copay for generic drugs • 20% for preferred brand-name drugs; your minimum cost is $30 and maximum cost is $65 per prescription • 40% for non-preferred brand-name drugs; your minimum cost is $40 and maximum cost is $100 per prescription	60% after deductible	• $20 copay for generic drugs • 20% for preferred brand-name drugs; your minimum cost is $60 and maximum cost is $130 per prescription • 40% for non-preferred brand-name drugs; your minimum cost is $80 and maximum cost is $200 per prescription
Your Care PPO Standard (Without HQ)	25% after deductible; your maximum cost is $500 per prescription	Not covered	25% after deductible; your maximum cost is $1,000 per prescription
Routine Care PPO Plus (When you take HQ)	• $10 copay for generic drugs • 30% for preferred brand-name drugs; your minimum cost is $35 and maximum cost is $70 per prescription • 40% for non-preferred brand-name drugs; your minimum cost is $50 and maximum cost is $100 per prescription	Not covered	• $20 copay for generic drugs • 30% for preferred brand-name drugs; your minimum cost is $70 and maximum cost is $140 per prescription • 40% for non-preferred brand-name drugs; your minimum cost is $100 and maximum cost is $200 per prescription
Routine Care PPO Standard (Without HQ)	35% after deductible; your maximum cost is $750 per prescription	Not covered	35% after deductible; your maximum cost is $1,500 per prescription

page
page
main table of contents
chapter table of contents
back
index
search

Your Share of the Cost

For certain prescriptions, you pay just a copay. For other prescriptions, you pay a percentage of the cost. It depends on your plan and the type of drug.

The amount you pay applies each time a prescription drug is dispensed to you. A payment applies to each prescription or refill. For medications dispensed as packaged kits, a payment applies to each kit.

Reduced Payments for Preventive Drugs

For the Plus version of the medical plans, generic copays are waived and the amount you pay for formulary brand name drugs are reduced by 50% for the preventive medication classes listed below:

MEDICATION CLASS	MEDICAL CONDITION
Ace inhibitors	Hypertension, diabetes
Beta-blockers	Hypertension
Diuretics	Hypertension
Anti-hypertensives	Hypertension
Calcium channel blockers	Heart disease and hypertension
Anti-hyperlipidemics	High cholesterol
Anti-diabetic drugs	Diabetes
Blood thinning agents	Coronary artery disease, heart disease
Diabetic supplies	Diabetes
Asthma supplies and anti-asthmatics	Asthma

For a detailed list of eligible preventive medications, go to the Health Plans page at www.mysbuxben.com.

What Is a Prescription Drug?

A prescription drug is any medical substance, the label of which, under the Federal Food, Drug and Cosmetic Act, is required to say: "Caution: Federal law prohibits dispensing without a prescription."

Benefits will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of the condition by one of the following standard references:

- The American Hospital Formulary Service-Drug Information
- The American Medical Association Drug Evaluation
- The United States Pharmacopoeia-Drug Information
- Other authoritative references as identified by the U.S. Secretary of Health and Human Services or the Insurance Commissioner

If not recognized by one of the standard references, then recognized by the majority of relevant, peer-reviewed medical literature, or the U.S. Secretary of Health and Human Services.

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contraindicated, or for experimental or investigational drugs not otherwise approved by the FDA.

What Is Covered?

Benefits are provided for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered under this benefit are injectable supplies.

The following items are covered when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and prescription vitamins, including coverage for off-label use of FDA-approved drugs as provided under this plan's definition of a prescription drug
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications; also covered are disposable diabetic testing supplies: test strips, testing agents and lancets
- Drugs to treat infertility, including fertility-enhancement medications
- Prescription contraceptives and devices (e.g., oral drugs, diaphragms and cervical caps)
- Prescription drugs for the treatment of nicotine dependency
- Injectable supplies

When insulin needles and syringes are purchased along with insulin, only the copay or coinsurance for the insulin will apply.

When insulin needles and syringes are purchased separately, the Preferred List Brand Name Drug copay or coinsurance will apply for each item purchased.

The Preferred List Brand Name Drug copay or coinsurance will apply to purchases of alcohol swabs, test strips, testing agents and lancets. A separate copay applies to each item purchased.

What is a preferred drug?

A list of generic and brand-name drugs are included in your medical plan's formulary (the list of preferred medications). Drugs included in the Premera Medco formulary have gone through an extensive review process. Your cost is lower when you use preferred drugs. Visit Premera Online, accessed through the Health Plans page at www.mysbuxben.com, for a list of preferred formulary drugs.

Generic vs. brand-name drugs

Prescription drugs are either generic or brand-name medicines. Generic drugs have the same active ingredients as brand-name drugs, and are dispensed in the same form (tablet, capsule, liquid, etc.) and recommended dosage as the brand-name equivalent. The difference is that generics cost substantially less.

Brand-name drugs are produced by the original manufacturer and usually cost much more than a generic alternative, when available. You pay a higher copay for brand-name drugs than for generics. The highest drug copay is for non-preferred brand-name drugs, which are drugs that are not on the formulary list.

Mandatory generics

The Plus versions of the Starbucks medical plans administered by Premera will automatically substitute a generic medication, when available, for any brand-name drug prescribed by your doctor (unless your doctor indicates "dispense as written"). If you choose to buy a brand-name drug instead of a generic, but a generic equivalent is available and substitution is allowed by the prescriber, you'll be required to pay the difference in price between the brand-name drug and the generic equivalent, in addition to paying the applicable copay or coinsurance.

If the pharmacy is unable to supply the generic drug at the time the prescription is presented, you will pay just the generic copay.

Medco By Mail Home Delivery Program

The mail-order drug program is part of your prescription drug benefit and is an easy, lower-cost way to obtain prescription drugs you use on a regular basis, such as oral contraceptives, and diabetic or heart medications. You can receive up to a 90-day supply by mailing in your share of the cost with your prescription. Once your initial prescription is filled through Medco By Mail, you can easily order refills over the phone, through the mail or online by selecting the link for Medco By Mail at Premera Online, accessed through the Health Plans page at www.mysbuxben.com. Prescriptions filled through Medco By Mail generally take from one to two weeks to arrive.

Medco By Mail claim forms may be requested online at www.mysbuxben.com. Link to the Forms/Resources page or contact Premera Partner Services at (877) 728-9020 to request a form.

For more information about filling a new prescription through Medco By Mail or for questions about coverage of a particular medication, call Premera at (877) 728-9020.

Specialty Pharmacy Program

Specialty drugs are used to treat complex or rare conditions and require special handling, storage, administration or patient monitoring. They are high-cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis. The plan uses Premera's contracted specific specialty

pharmacies that specialize in the delivery and clinical management of specialty drugs. These pharmacies will work with you and your health care provider to arrange ordering and delivery of these drugs.

Benefits for specialty drugs dispensed through the specialty pharmacy program are limited to a 30-day supply and are covered as other retail drugs.

Contact Premera Partner Services at (877) 728-9020 for details on which drugs are included in the Specialty Pharmacy Program.

What Is Not Covered

These drugs or supplies are not covered by your prescription drug benefits:

- Devices of any type, unless specifically included as prescription drugs
- Drugs entirely consumed at the time and place they are prescribed
- Contraceptive drugs, except oral contraceptives (see "Family Planning Services" on page 64 for information on contraceptive devices, injectable contraceptives and Norplant)
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Weight management drugs or appetite suppressants
- Drugs and medicines that may be legally obtained over the counter (OTC) without a prescription; OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this summary. Examples include non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g., infant formulas or protein supplements)
- Any drug that has an over-the-counter equivalent
- Immunization agents
- Biological sera and blood products or blood derivatives
- Allergy sera/extracts
- A supply for more than 30 days per prescription for each refill, unless provided by Medco By Mail
- Any refill of a drug if it is more than the number of refills specified by the prescriber
- Any refill of a drug dispensed more than one year after the date of the original prescription
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility; exceptions are for growth hormones or drugs provided as part of the plan's Specialty Pharmacy provision, which are covered regardless of where they are administered
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications; exceptions are injectable drugs for self-administration, such as insulin and glucagon, and growth hormones
- Administration or injection of any drug
- Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy, including but not limited to:
  - » Sildenafil citrate

page
page
main table of contents
chapter table of contents
back
index
search

  - » Phentolamine
  - » Apomorphine
  - » Alprostadil
  - » Any other drug that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes (this exclusion applies whether or not the drug is delivered in oral, injectable or topical forms — including but not limited to gels, creams, ointments and patches)
- Performance, athletic performance or lifestyle enhancement drugs or supplies
- Illegal drugs
- Drugs for experimental or investigational use
- Immunizations for foreign travel
- Drugs prescribed by an unlicensed health care provider
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth
- Replacement of a lost or stolen medication

If You Take an Approved Leave of Absence

Your medical coverage may continue during an approved leave of absence as outlined on page 27. However, you will be required to continue to pay for your medical coverage during your leave of absence.

Contributions for medical coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your contribution payments while on leave of absence, your coverage may be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

When Coverage Ends

If you are no longer a Starbucks partner, your prescription drug coverage ends on the last day of the month in which your termination is processed by payroll.

If you lose benefits eligibility due to the ongoing eligibility audit, your prescription drug coverage ends as described in the Eligibility and Enrollment chapter.

You can elect to continue your coverage through COBRA as outlined in "Your COBRA Rights" on page 254. If you are waiting for ordered and undelivered prescriptions when your coverage ends, and you were eligible and enrolled at the time your prescriptions were ordered, your ordered and undelivered prescriptions will be covered.

How to File a Claim

When you use a participating pharmacy, the pharmacy will file your claims for you. You will simply pay your share at the time you obtain your prescription. If you fill a prescription at a nonparticipating pharmacy or prior to receiving your Premera medical ID card, you will need to submit a claim for reimbursement.

To submit a claim, complete the employee section of the prescription drug claim form, attach your prescription receipt and mail it to the address shown on the claim form. Claim forms, including mail-order drug forms, may be obtained online at www.mysbuxben.com. Link to the Forms/Resources page or call Premera Partner Services at (877) 728-9020.

Claim procedure

If you submit a claim, you will be notified of the claim decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside of Premera's control. In that case, you will be notified of the extension before the end of the initial 30-day period. For example, it may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information.

You will be notified of Premera's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier). If your claim is denied, either in whole or in part, you can appeal the claim denial by following the process described on page 246.

Questions?

For general questions about your prescription drug benefits, call Starbucks Benefits Center at (877) SBUXBEN. If you have specific questions related to coverage of a prescription drug, call Premera Partner Services at (877) 728-9020. To find out more about having a new prescription filled through the mail-order program or to ask questions about your mail-order refill, you can contact Medco By Mail at (800) 391-9701.

If you are enrolled in HMSA, Kaiser California or Kaiser Hawaii, refer to your health provider's guide to pharmacy benefits.

Dental

Starbucks dental plan, administered by Premera, helps you pay for a wide range of dental expenses. When you visit a Premera preferred dental care provider, you'll pay less for your care.

To receive dental coverage, you must be enrolled in the dental plan, as described in the Eligibility and Enrollment chapter.

When you receive dental care, you may also have some out-of-pocket costs. Your dental plan may require you to pay these expenses before benefits are paid.

How the Plan Works

Plan year dental deductible

The dental deductible is the amount you pay for basic and major services each plan year before the plan begins to cover your expenses. Diagnostic and preventive covered services aren't subject to the deductible.

The plan year dental deductible is $50 for each covered member. When the total equals $150, the individual dental deductible of every enrolled family member will be met for the plan year. Only the amounts used to satisfy each family member's individual dental deductible will count toward the family plan year dental deductible.

Allowable charges

The plan will cover expenses based on allowable charges. You and your enrolled dependents are responsible for any charges that exceed allowable charges. If you use a Premera preferred provider, you and your enrolled dependents are not responsible for any charges that exceed the allowable charge, unless you have exceeded the benefit maximum.

An *allowable charge* for a service or supply is the lowest of:

- The provider's usual charge for furnishing it, or
- The charge Premera determines to be appropriate based on such things as the cost for the same or a similar service or supply and the way in which it was billed.

Any amounts you pay over allowable charges will not apply to the dental deductible.

ID cards

After you enroll, Premera will mail an ID card to your home. Take this card with you every time you visit the dentist. If you do not receive an ID card within your first month of coverage, contact Premera at (877) 728-9020.

page
page
main table of contents
chapter table of contents
back
index
search

Providers you can use

You can receive care through a state licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her license or certification, as allowed by the law. This plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

Using a preferred dental care provider

If you choose to receive care from a dentist in Premera's preferred dentist network, you will pay less for dental care. You do not need to select a preferred dental provider at the time you enroll, but you will save money each time you visit a preferred dental provider for dental care. When you receive dental care from a Premera preferred provider, you are billed a lower, preferred fee. Therefore, your portion is also lower, and you save money! Here is an example.

SERVICE	NON-PREFERRED DENTIST	PREFERRED DENTIST
Major service — crown	$1,050	$812
Plan pays 50%	$525	$406
You pay remaining 50%	$525	$406
Savings using a preferred dentist		**$119**

You can locate a preferred dental care provider by linking to Premera's website from www.mysbuxben.com or by contacting Premera at (877) 728-9020.

Your Health Care Reimbursement Account Covers Dental Expenses

If you have a health care reimbursement account and have out-of-pocket dental expenses, you may be reimbursed for these expenses from your account. Out-of-pocket expenses include your dental deductibles and coinsurance and may include charges not covered by the dental plan. Refer to the Reimbursement Accounts chapter for more information.

Covered Dental Services

Starbucks dental plan covers treatments that are dentally necessary, considered appropriate, used nationwide and meet broadly accepted national standards of dental practice. When you use a non-preferred dentist, you may be required to pay for services when you receive them, then file a claim for reimbursement.

Preventive services

THE PLAN PAYS	YOU PAY	
	Premera preferred provider	Nonpreferred provider
100%, no deductible applies	$0	Any amount exceeding allowable charges

Preventive services include:

- Oral exams and cleanings (limited to 2 exams and cleanings per plan year)
- Problem-focused and emergency exams
- Oral pathology laboratory (excluding removal of tissue)
- Dental x-rays, including either a complete series or panoramic x-ray once in any 36 consecutive months, but not both
- One set of four bitewings two times per plan year
- Topical application of fluoride or fluoride varnish for enrolled members under age 20 (up to 2 times per plan year)
- Space maintainers for enrolled members under age 20 are only covered when designed to preserve space for permanent teeth
- Sealants for permanent teeth for enrolled members under age 15 (limited to once in any 36 consecutive months per tooth)

Basic services

THE PLAN PAYS	YOU PAY	
	Premera preferred provider	Nonpreferred provider
80% after a $50 plan year deductible	The remaining 20%	The remaining 20% plus amounts exceeding allowable charges

Basic services include:

- Emergency palliative treatment; a written description and/or office records are required
- Dentally necessary therapeutic injections administered in a dental office
- Antibiotic drugs administered or dispensed in the dental office
- Fillings consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months. Resin based composite fillings performed on second and third molars are considered cosmetic and will be reduced to the amalgam allowance.
- Prefabricated stainless steel crowns are covered once per tooth in any 24 consecutive months
- Limited occlusal adjustments are covered once in any 12 consecutive months
- Root canals and other endodontic treatment, covered once per tooth in any 24 consecutive months
- Periodontal maintenance, as a follow-up to active periodontal treatment, is covered up to four times per plan year (prophylaxis is not covered in conjunction with periodontal maintenance)
- Full-mouth debridement is covered once in any 36 consecutive months (covered only if there is no history of prophylaxis (cleaning) or periodontal service)
- Periodontal scaling and root planing are covered once per quadrant in any 24 consecutive months
- Osseous and mucogingival surgery (surgical periodontal treatment) is covered once per quadrant in any 36 consecutive months
- Simple and surgical extractions

page
page
main table of contents
chapter table of contents
back
index
search

- Oral surgery related to the tooth and gum
- General or intravenous anesthesia in a dental care provider's office for covered dental services
- Relining or rebasing dentures, when performed six or more consecutive months after denture installation
- Repair or recementing of crowns, inlays, bridgework or dentures, when performed six or more consecutive months after initial placement

Major services

THE PLAN PAYS	YOU PAY	
	Premera preferred provider	Nonpreferred provider
50% after $50 plan year deductible	50%	50% plus amounts exceeding allowable charges

Major services include:

- Initial placement of inlays, onlays, labial veneers, crowns and gold foils; crowns, inlays and onlays consisting of porcelain, ceramic or resin performed on second or third molars will be limited to what would have otherwise been allowed for a full gold crown
- Initial placement of a denture or fixed bridge to replace one or more natural teeth extracted while covered by Starbucks dental plan
- Replacement of inlays, onlays, labial veneers and crowns that cannot be repaired and are at least five years old
- Replacement of an existing denture or fixed bridge may be covered in either of the cases below:
  - The present denture or bridgework cannot be repaired and is at least five years old
  - The present denture or bridgework requires the replacement or addition of teeth; you must have been covered by Starbucks dental plan when the tooth was extracted
- Adjustment of dentures when performed six or more consecutive months after denture installation
- Tooth crown and core build-ups for covered crowns, including bridge abutments, when dentally necessary
- Night-guards and repair and/or reline are covered once in any 36 consecutive months

Orthodontic services

THE PLAN PAYS	YOU PAY	
	Premera preferred provider	Nonpreferred provider
50% up to a $1,500 lifetime maximum per member	50% up to $1,500 lifetime maximum per member and 100% of amounts over the benefit maximum	50% up to $1,500 lifetime maximum per member and 100% of amounts over the benefit maximum

Orthodontic services include:

- Diagnostic services and supplies, including examinations, x-rays, models and photographs
- Active treatment, including initial and subsequently necessary appliances
- Retention treatment

page
page
main table of contents
chapter table of contents
back
index
search

What are dentally necessary services?

Dentally necessary services or supplies are those Premera determines are dentally necessary for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are:

- Equal in quality to, and not costlier than, any other alternative treatment, care or diagnosis
- In accordance with generally accepted standards of dental practice
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, dentist, or other dental care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

When determining necessary services or supplies, Premera considers factors such as the patient's health condition, reports and guidelines published by nationally recognized health care organizations and professionals, information from medical literature and more.

Prosthesis replacement rule

Starbucks dental plan covers certain replacements or additions to existing dentures or bridgework, as long as:

- The present denture or bridgework cannot be repaired and is at least five years old.
- The present denture or bridgework requires the replacement or addition of teeth. You must have been covered by Starbucks dental plan when the tooth was extracted.
- The existing denture is temporary, only exists to replace any natural teeth extracted while you were covered under Starbucks dental plan and cannot be made permanent. Replacement by a permanent denture must be necessary and must take place within 12 months from the date the temporary denture was first installed.

Replacement (e.g., bridge, implants, etc.) of congenitally missing teeth is covered as a major service provided the service is completed when the jaw is done growing and the solution is now permanent. The service must be completed before the member's 21st birthday to be covered.

What is not dentally necessary?

The following items are not considered dentally necessary:

- Services or supplies that do not require the technical skills of a medical or dental professional
- Services or supplies furnished mainly for the personal comfort or convenience of the patient, caretaker, family, health care provider or health care facility
- Services or supplies provided while you are being treated as an inpatient but when you could receive treatment, care or diagnosis as an outpatient
- Services or supplies furnished because of the setting when they could be safely and adequately provided in a physician's or dentist's office or another less costly setting

page
page
main table of contents
chapter table of contents
back
index
search

Maximum benefit per plan year

The maximum benefit that will be paid by Starbucks dental plan for preventive, basic and major services each plan year per covered member is:

- $1,000 for the first plan year you are covered
- $2,000 for each plan year after that

The maximum lifetime benefit that will be paid for orthodontic services is $1,500 per covered member.

Special Rules Apply to Your Maximum Benefit

- If you lose benefits eligibility during one plan year and re-establish eligibility the following plan year, your maximum benefit will be $1,000 for the first plan year after re-establishing eligibility.
- If you lose and re-establish benefits eligibility within the same plan year, your maximum dental benefit will be reinstated at the level it was when you lost eligibility.

Estimate of dental benefits

An estimate of dental benefits is recommended for any dental services that exceed $350. This typically includes most basic and all major and orthodontic services. The purpose of an estimate of dental benefits is to inform you and your dental care provider, in advance, of what the plan covers for the proposed treatment prior to any coordination of benefits. If alternative services and supplies may be used to treat your dental condition, the plan will cover the least costly, professionally appropriate treatment. If you and your dental care provider choose a more costly treatment, you're responsible for the additional charges beyond those for the less costly alternative treatment.

To obtain an estimate of dental benefits, you or your dental care provider will need to submit to Premera your provider's proposed course of treatment and estimated charges. Within 72 hours after Premera receives the fully documented request, Premera will determine whether the service meets the standards for coverage under this plan. It is strongly recommended that you request an estimate of dental benefits so that benefit questions are answered before your course of treatment begins. If your dental care provider makes a major change in the treatment plan, he or she should submit a revised plan.

If you do not request an estimate of dental benefits before starting a dental course of treatment, you may not receive optimal benefits from the plan. Plan ahead and find out what is covered before you start basic or major dental treatments.

Coordination of Benefits

You may be covered under more than one dental plan. To avoid duplicating benefits, most dental plans—including Starbucks—have what is called a coordination of benefits provision. See page 241 for examples of how this works.

What Is a Course of Treatment?

A course of treatment is a planned program of one or more services or supplies needed to treat your dental condition. Your dental care provider must have diagnosed the condition during an oral exam, but the treatment itself may be given by one or more dental care providers.

The course of treatment starts on the date you first receive treatment to correct or treat the dental condition. However, some services may be provided before you request an estimate of dental benefits, such as emergency treatments, oral exams (including prophylaxis) and x-rays.

What Is Not Covered

The following services are not covered by the dental plan but may be covered, at least in part, by your Starbucks medical plan, if enrolled.

Treatment of the mouth, jaws and teeth

Starbucks medical plans may cover eligible expenses for treatment of certain conditions of the teeth, mouth, jaws, jaw joints or supporting tissues (including bones, muscles and nerves). Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects, is not covered.

TMJ or MPD treatment

Starbucks dental plan does not cover temporomandibular joint disorder (TMJ) or myofacial pain dysfunction (MPD) treatments. Nonsurgical treatments may be covered by Starbucks medical plans if treatment is medically necessary.

Other items not covered

Starbucks dental plan also does not cover the following items:

- Treatment by someone other than a licensed dentist (D.M.D. or D.D.S.); however, some treatments by a licensed dental hygienist supervised by a dentist are covered, including scaling of teeth, cleaning of teeth and topical application of fluoride
- Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures; treatment of congenital malformations, except when the patient is an eligible dependent
- Replacement of a lost, missing or stolen prosthetic device
- Temporary, interim or provisional services for crowns, bridges or dentures
- Services or supplies to increase vertical dimension, including dentures, crowns, inlays, onlays, bridgework and any other appliance or service intended to increase vertical dimension
- Charges for which you are not legally obligated to pay

page
page
main table of contents
chapter table of contents
back
index
search

- Charges for the treatment of any condition related to or arising from previous or current employment or occupation, or serving in the armed forces
- Expenses in excess of allowable charges, as determined by Premera
- Charges for services and supplies that are not dentally necessary for the diagnosis, care or treatment of the condition, as determined by Premera (this applies even if they are prescribed, recommended or approved by your doctor or dentist)
- Charges for treatment, services or supplies that are not prescribed, recommended and approved by your attending doctor or dentist
- Surgical procedures to correct malocclusion
- Occupational diseases or injuries (defined on page 110)
- Amounts in excess of a maximum benefit for a covered service
- Amounts that are billed for broken or late appointments
- Separate charges from providers for supplying records or reports, except those requested for utilization review
- Charges for case presentation or extensive treatment planning
- Dietary planning or nutritional counseling for the control of dental caries, oral hygiene instruction and training in preventive dental care
- Precision attachments
- Any service or supply that is determined to be experimental or investigational (defined on page 110) on the date it's furnished, and any direct or indirect complications and aftereffects
- Replacement of amalgam or resin-based composite fillings due to mercury or other allergic reactions
- Hospital and ambulatory surgical center care for dental procedures
- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption; examples of such providers are your spouse, parent or child
- Services and supplies that are normally intended for home use such as take-home fluoride, tooth brushes, floss and toothpaste
- Dental visits or procedures received in your home
- Services provided by more than one dental care provider for the same dental procedure
- Non-standard techniques used in the making of restorations or prosthetic appliances
- Services that are not listed as covered or that are directly related to any condition, service or supply that isn't covered under this plan
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for major services and root canals that:
  - Were started after your effective date and before the date your coverage ended under this plan, and
  - Were completed within 90 days after the date your coverage ended under this plan

page
page
main table of contents
chapter table of contents
back
index
search

- The following are deemed service start dates:
  - For root canals, the date the canal is opened
  - For inlays, onlays, labial veneers, crowns and bridges, the preparation date
  - For partial and complete dentures, the impression date
- The following are deemed service completion dates:
  - For root canals, the date the canal is filled
  - For inlays, onlays, labial veneers, crowns and bridges, the seat date
  - For partial and complete dentures, the seat or delivery date
- Orthodontia, except as specified as a covered benefit
- Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the jurisdiction in which the services or supplies were received
- Any prescription drugs or medicines, including vitamins, food supplements and patient management drugs, such as premedication, sedation and nitrous oxide
- Testing and treatment for mercury sensitivity or that are allergy-related
- Genetic or caries susceptibility tests
- Tobacco counseling for the control or prevention of oral disease
- Implant and implant-related services, except as stated for congenitally missing teeth
- Oral airway orthotics for obstructive sleep apnea
- Services provided by a dentist to other areas of the oral region other than the tooth and gum (i.e., lips, tongue and cheeks)
- Dental care services for accidental injuries; these services may be covered by a Starbucks medical plan if medically necessary

What Is an Experimental Procedure?

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Reliable evidence includes but isn't limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center (TEC).

Decisions regarding experimental or investigational services are based on the criteria stated above as determined by Premera.

What Is an Occupational Disease or Injury?

An occupational disease or injury is one that arises out of — or in the course of — any work for pay or profit. Only nonoccupational accidental injuries and diseases are covered by Starbucks dental plan. A disease is nonoccupational, regardless of cause, if proof is furnished that the person is covered under any type of workers' compensation law but is not covered for that disease under such law.

If You Take an Approved Leave of Absence

Your dental coverage may continue during an approved leave of absence, as outlined on page 27. However, you will be required to continue to pay for your dental coverage during your leave of absence. Contributions for dental coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your contribution payments while on leave of absence, your coverage may be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

page
page
main table of contents
chapter table of contents
back
index
search

When Coverage Ends

If you are no longer a Starbucks partner, your dental coverage ends on the last day of the month in which your termination is processed by payroll.

If you lose benefits eligibility due to the ongoing eligibility audit, your dental coverage ends as described in the Eligibility and Enrollment chapter.

You may elect to continue your coverage through COBRA as outlined in "Your COBRA Rights" on page 254.

If you are waiting for ordered and undelivered services when your coverage ends, and you had ordered certain dental services or supplies while you were covered, the plan will cover those ordered and undelivered services. These include:

- Dentures
- Fixed bridgework
- Crowns

These supplies will be covered only if they are installed or delivered within 90 days after your coverage under Starbucks dental plan ends.

Ordered services means you have had impressions taken for dentures, crowns or fixed bridgework, or your teeth have been prepared for fixed bridgework or crowns.

How to File a Claim

Usually, providers will automatically submit a claim directly to Premera for services you have received. Premera will reimburse the dental office for what the plan covers and you will be responsible for paying the dental office the balance due. You may be asked to sign and submit a claim form periodically in order for the dental office to continue to automatically bill Premera.

You may need to submit claims for any basic or major dental services you receive except when you use a Premera *preferred provider*. File your claims with Premera within 90 days of receiving your treatment.

To submit a claim, complete the employee section of the claim form, attach an itemized bill and mail it to the address shown on your Premera Dental ID card. Or, have your dental office complete the provider portion of the claim form and submit it directly to Premera at the address shown on your ID card.

Claim forms are available online at www.mysbuxben.com. Link to the Forms/Resources page or contact Premera Partner Services at (877) 728-9020 to request a claim form.

Questions?

For answers to your questions about the Starbucks dental plan, call Premera at (877) 728-9020.

page
page
main table of contents
chapter table of contents
back
index
search

Vision

Starbucks vision plan provides you and your enrolled dependents coverage for eye exams, prescription glasses and contacts. The plan is offered through VSP, which has a national network of eyecare providers.

To receive vision coverage, you must be enrolled for vision benefits as described in the Eligibility and Enrollment chapter.

How the Plan Works

When you visit a VSP network provider, you will typically receive a higher level of coverage from the plan. If you choose to visit a non-VSP provider, you will still have coverage but may not receive as high of a benefit. In addition, with a non-VSP provider you must pay for services up front and submit a claim to VSP for reimbursement.

Finding a VSP network provider

To access a VSP network provider:

- Link to VSP's website from the health plans page on www.mysbuxben.com.
- Call VSP at (800) 877-7195, tell them you are a Starbucks partner and request a listing of VSP network providers in your area.

Visiting a VSP network provider

To visit a VSP network provider, just follow these steps:

- Call and make an appointment, identifying yourself as a VSP member.
- Pay your copays for your exam and prescription glasses (lenses and frame) or contacts if you are purchasing them.
- Pay for any discounted lens options, such as tints, coatings and progressive lenses not covered by the plan, and any amount exceeding the VSP frame allowance.

There is no ID card for the vision plan. When you are making your appointment with a VSP network provider, simply let them know you are a VSP member. Your provider will confirm your eligibility prior to your appointment.

Visiting a non-VSP provider

You get the best value from your VSP benefit when you visit a VSP network provider. However, you may visit any licensed optometrist, ophthalmologist or dispensing optician. If you decide not to see a VSP provider, copays still apply. You will also receive a lesser benefit and typically pay more out of pocket. You are required to pay the provider in full at the time of your appointment and then submit a claim for reimbursement to VSP. See "How to File a Claim" on page 117.

page
page
main table of contents
chapter table of contents
back
index
search

What Is a Copay?

Your copay is the flat fee you pay out of pocket each time you receive vision care or purchase eyewear, such as glasses or contacts. You may incur additional out-of-pocket costs beyond what is covered by the vision plan.

What the Plan Covers

The vision plan covers specific vision services and eyewear as described in this section. Your coverage varies depending on whether you see a VSP network provider or a non-VSP provider.

Eye exams

The vision plan covers one eye exam per calendar year.

Prescription glasses and contacts

Prescription glasses and contacts are covered by the vision plan as follows:

Lenses and frames

- One pair of frames is covered once every two calendar years.
- Up to one pair of lenses is covered per calendar year.
- Tints, coatings, progressive lenses and other lens options are not covered, but may be purchased at a 35-40% discount from your VSP network provider.

Contacts

- One pair of elective contacts is covered per calendar year. However, if you choose to purchase elective contacts instead of glasses, you are not covered for glasses in the same calendar year. Additionally, you are not eligible for frames until the second calendar year following the year you receive coverage for your elective contacts. For example, if you choose contacts in 2010, frames will not be covered until 2012.
- One pair of medically necessary contacts is covered in full by the plan per calendar year if required for certain medical conditions and approved by VSP. Medically necessary means that your eye doctor has determined that contacts are medically required to correct your vision, which cannot be corrected by glasses.

Health Care Reimbursement Accounts Cover Vision Expenses

If you are a salaried or nonretail hourly partner participating in a health care reimbursement account and pay any out-of-pocket vision expenses, you may be reimbursed for these expenses from your health care reimbursement account. Out-of-pocket expenses include copays and items not covered by the vision plan. See the Reimbursement Accounts chapter for more information.

page
page
main table of contents
chapter table of contents
back
index
search

Vision plan coverage overview

SERVICES	WHEN YOU VISIT A VSP NETWORK PROVIDER	WHEN YOU VISIT A NON-VSP PROVIDER
	Copay applies	**Copay applies**
Eye exams One per calendar year	You pay $10 copay per exam The plan pays remaining balance	You pay exam charges in full The plan reimburses you up to $40
Frames One pair every 2 calendar years	The plan pays up to $125 retail frame allowance You pay any charges over the frame allowance (you will receive a 20% discount on any cost over your $125 allowance)	The plan reimburses you up to $50 You pay any remaining balance
Lenses Up to one pair of lenses per calendar year, excluding tints, coating and other lens options	You pay $25 copay plus any charges for cosmetic lens options not covered by the plan The plan pays remaining balance for single vision, lined bifocal and lined trifocal lenses	You pay lens cost in full The plan reimburses you up to: • $40 for single vision • $60 for lined bifocal • $80 for lined trifocal • $125 for lenticular (when medically necessary and pre-authorized by VSP)
Contacts Medically necessary and instead of glasses	You pay $25 material copay The plan pays remaining balance	You pay lens cost in full The plan reimburses you up to $210, less any applicable copay
Contacts Elective and instead of glasses	The plan pays up to $125, applies to your contacts and contact lens exam (evaluation and fitting charges) You pay any remaining balance	You pay lens cost in full The plan reimburses you up to $125

Laser VisionCare℠ program

VSP's Laser VisionCare℠ program includes comprehensive information on laser vision correction surgery, as well as giving you substantial savings on the procedure.

VSP has arranged for you to receive PRK, LASIK and Custom LASIK services at a discounted fee averaging 15% less than you might otherwise pay. To use Laser VisionCare℠, visit VSP's website by linking from the Health Plans page at www.mysbuxben.com or call your VSP network provider to check if he or she is participating in the program. Schedule a screening and consultation with your VSP network provider. If, in consultation with your VSP network provider, you decide to proceed with laser vision correction, your VSP network provider will coordinate your care with a VSP laser surgeon. If you do not use a VSP network provider, you will not receive these discounted fees.

page
page
main table of contents
chapter table of contents
back
index
search

Additional Discounts

VSP network providers also offer these extra discounts and savings:

- You receive up to 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your eye exam. Or get 20% off from any VSP doctor within 12 months of your last eye exam.
- You receive up to 40% savings on lens extras such as scratch-resistant and anti-reflective coatings and progressives (no-line bifocals and trifocals).
- You receive a 15% discount on a contact lens exam (fitting and evaluation) when obtained from a VSP network provider. New and current soft contact lens wearers may be eligible for a special program that includes an initial contact lens evaluation and initial supply of lenses.
- You receive laser vision correction discounts.

Call VSP Member Services at (800) 877-7195 for more information.

What Is Not Covered

The vision plan does not cover vision services and eyewear if they are covered, in whole or in part, under any medical plan.

In addition, the following items are not covered by the vision plan:

- Orthoptics or vision training and any associated supplemental testing
- Plano nonprescription lenses
- Two pairs of glasses instead of bifocals
- Replacement of lenses and frames paid for by the plan that were lost or broken
- Medical or surgical treatment of the eyes
- Corrective vision services, treatments and materials of an experimental nature

If You Take an Approved Leave of Absence

Your vision coverage may continue during an approved leave of absence as outlined on page 27. However, you will be required to continue to make your contribution payments for vision coverage during your leave of absence. Contributions for vision coverage will be collected (depending on your length of leave) through either direct billing from Starbucks Benefits Center or retroactive payroll contributions upon your return to work. If you do not make your contribution payments while on a leave of absence, your coverage may be cancelled. Call Starbucks Benefits Center at (877) SBUXBEN for more information.

When Coverage Ends

If you are no longer a Starbucks partner, your vision coverage ends on the last day of the month in which your termination is processed by payroll.

If you lose benefits eligibility due to the ongoing eligibility audit, your vision coverage ends as described in the Eligibility and Enrollment chapter. You may elect to continue your coverage through COBRA as outlined in "Your COBRA Rights" on page 254.

How to File a Claim

When you visit a VSP network provider

Your VSP network provider takes care of all the paperwork for you, so you do not need to file a claim if you visit someone in the VSP network.

When you visit a non-VSP provider

When you visit any non-VSP provider, you must pay for services at the time you receive them and then submit a claim for reimbursement up to the plan coverage amount.

To file a claim, you do not need a form. Just send an itemized receipt to VSP. The receipt should include:

- A list of services received
- Your name, current address, phone number and Social Security number
- The patient's name, address, phone number and date of birth
- The name of Starbucks as your employer
- Your relationship to the VSP member, such as self, spouse, domestic partner or child

Send the claim within six months of visiting the non-VSP provider to:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Claim procedure

VSP will notify you of its decision within 30 days after your claim is filed. If, because of matters beyond the control of VSP, a decision cannot be made within 30 days, then the time period may be extended an additional 15 days. In that case, VSP will notify you before the end of the initial 30-day period that an extension is required.

If the extension is required because you fail to submit the information necessary, VSP will send you a notice describing the information it requires. You will then have at least 45 days from the date you receive the notice to provide the required information. VSP's 15-day extension will begin after you have submitted the required information, provided you did so within the time frame specified by VSP.

If you do not provide the required information, VSP may decide your claim without it. If your claim is denied, either in whole or in part, you may appeal by following the process described on page 246.

Questions?

For answers to your questions about the vision plan, call VSP Member Services at (800) 877-7195.

page
page
main table of contents
chapter table of contents
back
index
search

Reimbursement Accounts

Starbucks offers eligible partners the opportunity to participate in health care and dependent care reimbursement accounts. With these accounts, you can set aside before-tax dollars up to defined limits to pay for qualifying health care and dependent care expenses.

How the Plans Work

To participate in reimbursement accounts, you must be a salaried or nonretail hourly partner and eligible for Starbucks benefits. Once you establish eligibility, you can enroll in either the health care reimbursement account (HCRA), the dependent care reimbursement account (DCRA), or both. The two plans are similar in how they work, but they are separate accounts and differ in some important ways.

If you enroll, Starbucks will automatically deduct your contributions from your paychecks before taxes are withheld and deposit them in your reimbursement account(s). You do not pay taxes on the money you put into the account or on the money taken out of the account in the form of reimbursements (including Social Security and Medicare [FICA] taxes, federal income tax and, in most areas, state and local income taxes).

The dollars you contribute to the accounts are not taxed, and therefore the IRS imposes limits on how those dollars may be reimbursed to you. For example, the IRS determines what is considered a qualifying expense, the last day you can file your claims and who is considered a qualifying dependent.

Estimate your tax savings online

You can estimate your reimbursement account tax savings using the savings calculator on www.mysbuxben.com.

Evaluating the best tax advantage

Before you enroll in a reimbursement account, weigh the tax advantages. You may find that it is more tax advantageous for you to claim a deduction or credit on your federal income tax rather than use a reimbursement account. For example, if you have medical expenses totaling more than 7.5% of your adjusted gross income each year, you may be able to deduct them as medical expenses on your tax return. If you have dependent children, you may already be taking advantage of the federal child and dependent care tax credit.

To see whether Starbucks reimbursement accounts make more sense for your personal tax situation, obtain a copy of the *IRS publications 502 (Medical and Dental Expenses)* and *503 (Child and Dependent Care Expenses)* and talk with a tax advisor. These publications are available online at www.irs.gov.

There are several tax considerations to keep in mind when deciding whether or not to participate in Starbucks reimbursement accounts:

- You cannot claim a tax deduction or take a tax credit for the same expenses that you have been reimbursed for through your reimbursement account.
- Tax credits and tax deductions reduce your income tax at the time you file your tax return. Reimbursement accounts reduce your income tax withholding throughout the year.
- Participating in a reimbursement account may reduce your future Social Security benefits.

Tax laws require Starbucks to review reimbursement account contributions to ensure the accounts do not favor highly compensated partners. Depending on the results of this review and your pay, some or all of the contributions made by highly compensated partners during the plan year may become taxable (see "Nondiscrimination testing" on page 128 for more information). Starbucks will notify you if this applies to you.

Which method is best for you: reimbursement accounts, tax credits or deductions? It all depends on your personal tax situation. You may want to talk to a tax advisor before you make a decision.

Participating in the plans

When you are first eligible for benefits, enrollment materials that guide you through the enrollment process will be mailed to your home address.

Estimate the amount you will spend on qualifying health care and dependent care expenses in a plan year and determine if reimbursement accounts make more sense than using the medical expense deduction or child care tax credit. If you initially establish benefits eligibility in the middle of a plan year or you have a *qualified status change*, remember to forecast your expenses and contributions over fewer pay periods. Your maximum contribution will be based on a per-pay-period maximum.

What Is a Plan Year?

The plan year is October 1 through September 30. You can be reimbursed for health care or dependent care expenses incurred during the plan year, as long as Premera receives your claims by the following December 31. A plan year differs from a calendar year, so you will need to keep this in mind when planning your annual health care or dependent care enrollment and when you are preparing your income tax returns.

If you enroll in reimbursement accounts, your calendar-year-to-date contributions will appear on your paycheck stub beginning one or two pay periods following the date your enrollment was processed. Your total contribution amount for the calendar year will appear on your W-2 form at the end of the year. You can check your account balance and view statements online 24 hours a day, 7 days a week when you log on your reimbursement accounts at Premera Online, accessed through the Health Plans page at www.mysbuxben.com.

If you experience a *qualified status change* during the year, such as adding a newborn or changing dependent care providers, you may be able to change your reimbursement account contributions. See "Making Changes" on page 24.

Annual open enrollment

Each year, during the annual benefits open enrollment period, you have the opportunity to participate in reimbursement accounts for the upcoming plan year. During this time, you can enroll for the first time, re-enroll or change the amount you are contributing. If you do not enroll, you will not participate in the next plan year. Even if you do not want to make any changes to the amount you are contributing, **you must re-enroll each annual open enrollment** period to continue participation.

page
page
main table of contents
chapter table of contents
back
index
search

Rules you should know

Certain IRS rules apply to reimbursement accounts:

- **Use it or lose it.** If you have money left in your reimbursement accounts at the end of the plan year, you lose that balance. You cannot apply the balance to the next plan year or receive a refund.
- **Submit your claims before December 31.** The money you contribute during a plan year — October 1 to September 30 — must be used for eligible expenses incurred during that same plan year. Premera must ***receive*** your claims for the previous plan year's eligible expenses by December 31.
- **You cannot combine accounts.** You cannot apply your health care contributions toward dependent care expenses, or vice versa.

Health Care Reimbursement Account (HCRA)

If you have health care expenses not covered by your medical, dental or vision plan, you may be able to pay for these expenses with before-tax dollars through the HCRA. You can participate in the HCRA even if you are not enrolled in a Starbucks medical plan.

Each year, you can contribute between approximately $100 and $5,000 to an HCRA:

FREQUENCY OF PAYCHECK	MINIMUM PER PAYCHECK	MAXIMUM PER PAYCHECK
Weekly	$1.92	$96.15
Biweekly	$3.84	$192.30

Only specific types of expenses can be reimbursed by your account and unused balances are forfeited at the end of the year.

What the account covers

You can be reimbursed for qualifying health care costs (medical, prescription drugs, dental, vision and over-the-counter drugs) for you, your children and your spouse — even if you or they are not covered by Starbucks health plans. Health care expenses for your domestic partner or same-sex spouse are reimbursable only if your domestic partner or same-sex spouse also qualifies as your dependent for federal tax purposes.

Qualifying health care expenses are those you have incurred that are not covered under any health plan you are enrolled in. They may include, but are not limited to:

- Deductibles, coinsurance amounts and copays for medical, prescription drug, dental and vision plans
- Over-the-counter drugs (not requiring a doctor's prescription)
- Artificial limbs and eyes
- Braille books and magazines for the visually impaired if they cost more than regular books
- Contact lenses and contact lens supplies
- Crutch purchase or rental
- Eye care and eyewear (excluding accessories)